DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/02/2008 FORM APPROVED OMB NO. 0938-0391

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE SURVEY COMPLETED		
			01 - MAIN BUILDING 01			
	095038	8. WING		06/30/2008		
		STREET ADDRESS, CITY, STATE, ZIP CODE 4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008				
(EACH DEFICIENCY MU	JST BE PRECEDED BY FULL REGULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE CROSS-	(X5) COMPLETION DATE	
Based on observation Safety Code survey findings were observed for the survey of the s	ations during the annual Life ey of your facility, the following erved on June 30, 2008. GAFETY CODE STANDARD corridor openings in other than es of vertical openings, exits, or are substantial doors, such as I of 1¾ inch solid-bonded core of resisting fire for at least 20 in sprinklered buildings are only the passage of smoke. There is the closing of the doors. Doors a means suitable for keeping the ch doors meeting 19.3.6.3.6 are .6.3 prohibited by CMS regulations in	K 000	SUBMITTED FOR PURPOSI REGULATORY COMPLIANC PART OF THE METHODIST ONGOING EFFORTS TO CONTINUOUSLY MAINTAIN HIGH QUALITY OF CARE AND SERVICES PROVIDED IT DOES NOT CONSTITUTE ADMISSION OF THE FACTS CONCLUSIONS CITED IN TI	ES OF CE AND AS HOME'S THE AS SUCH AN OOR		
Based on observatinspection it was dentrance door to right when tested. The presence of the MEmployee # 1.	ations during the Life Safety Code determined that double fire and esidents rooms failed to close se findings were observed in the laintenance Director,					
	INITIAL COMMENTAL Safety Code survey findings were obsomerated enclosurch hazardous areas those constructed wood, or capable minutes. Doors in required to resist no impediment to are provided with door closed. Dute permitted. 19.3 Roller latches are all health care factors are for the second of the Membrane of the Membrane of the Membrane of the Membrane minutes. The presence of the Membrane minutes.	O95038 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS Based on observations during the annual Life Safety Code survey of your facility, the following findings were observed on June 30, 2008. NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1% inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code inspection it was determined that double fire and entrance door to residents rooms failed to close when tested. These findings were observed in the presence of the Maintenance Director,	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS Based on observations during the annual Life Safety Code survey of your facility, the following findings were observed on June 30, 2008. NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code inspection it was determined that double fire and entrance door to residents rooms failed to close when tested. These findings were observed in the presence of the Maintenance Director, Employee # 1.	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF CORRECTICS SUBMITTED FOR PURPOSS REQULATORY COMPLIANC PART OF THE METHODIST NOONING EFFORTS TO CONTINUOUSLY MAINTAIN NOONING EFFORTS THIS PLAN OF CORRECTICS SUBMITTED FOR PURPOSS REQULATORY COMPLIANC PART OF THE METHODIST ONGOING EFFORTS THE METHODIST THE METHODIST THE METHODIST THE METHODIST THE METHODIST THE STANDARD IS NOT ONS THE PLATE ON THE METHODIST THE STANDARD IS NOT ONS THE PLATE ON THE METHODIST THE STANDARD IS NOT CONSTITUTE ADMISSION OF THE FACTS CONCLUSIONS CITED IN TO SUPPLY REPORT FOR ANY PURPOSE WHATSOEVER. TO THE METHODIST THE METHODIST THE SCAP CORRECTION SHOULD NOT CORRECTION SHOUL	OSPICE CORRECTION DENTIFICATION NUMBER: A BUILDING 01 - MAIN BUILDING 01	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

~ L V____

CED/ADMINISTRATOR

(X6) DATE & JULY 2008

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these focuments are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

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(X3) DATE SURVEY

COMPLETED

A. BUILDING 01 - MAIN BUILDING 01 B. WING 095038 06/30/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4901 CONNECTICUT AVENUE, NW **METHODIST HOME** WASHINGTON, DC 20008 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-**PREFIX** REFERENCED TO THE APPROPRIATE DEFICIENCY) OR LSC (DENTIFYING INFORMATION) TAG TAG K 018 Continued From page 1 K 018 K 018 NFPA Life Safety Code Standard Double fire doors and single entrance doors to Corrective Action for Residents Affected by Deficient resident 's rooms failed to close when tested 7/1/08 No resident(s) was(were) negatively impacted. The without assistance which would not prevent the entrance door to the laundry room, the double doors at the passage of smoke in the event of a fire. entrance to the Therapy room, the pantry doors and the entrance door to room 249 were adjusted allow for positive latching. 1. The entrance door to the laundry room failed to Method to Identify Other Residents At Risk for Deficient 2. close and latch into the door frame when tested in Practice: 7/1/08 one (1) of one (1) observation at 9:40 AM on June All doors in the Health Care Center were tested and 30, 2008. found to be closing and latching appropriately. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur. 2. Double doors located at the entrance to the Door latch check added to maintenance rounds. Nursing Physical Therapy failed to close and latch when also advised of latching requirement and reminded to notify 7/1/08 tested in one (1) of (4) observations at (9:45 AM on Maintenance if adjustments / repair to any doors are necessary. June 30, 2008. On a monthly basis, doors in the Health Care Center will be randomly checked by Director of Maintenance Services to 3. The pantry entrance door failed to close and latch ensure deficient practice does not recur. into the door frame when tested in one (1) of one (1) Performance Monitoring to Ensure Solutions Are Sustained: 7/24/08 Report findings in Quarterly QA meeting. Implementation date: observation at 9:50 AM on June 30, 2008. July 24, 2008 and quarterly thereafter x 4 quarters. 4. The entrance door to room 249 failed to close and latch into the door frame tested in one (1) of five (5) observations at 10:15 AM on June 30, 2008. K 130 NFPA 101 MISCELLANEOUS K 130 SS=E OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code inspection it was determined that the smoke detector in the dishwashing area of the main kitchen was covered with a sheet of plastic to prevent the alarm from sounding and a large fan in the dishwasher area was soiled with accumulated dust and insect carcasses. These

(X2) MULTIPLE CONSTRUCTION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 06/30/2008				
		095038							
NAME OF PROVIDER OR SUPPLIER METHODIST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				(X5) COMPLETION DATE				
K 130	K 130 Continued From page 2 findings were observed in the presence of Employee #1. The findings include: 1. The smoke detector located in the washing area of the main kitchen was improperly covered with sheet of plastic to prevent the alarm from sounding when temperatures are elevated in the dishwasher area in one (1) of one (1) observation at 9:20 AM on June 30, 2008. 2. A large overhead fan adjacent to the dishwasher was soiled with accumulated dust on the blade and cover surfaces and wall surfaces adjacent and below the fan were soiled with insect carcasses in one (1) of one (1) observation at 9:25 AM on June 30, 2008.		K 130	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1. Corrective Action for Residents Affected by Deficient Practice: No resident(s) was(were) negatively impacted. The plastic was removed from the detector in the dish machine room. The large fan was cleaned thoroughly. 2. Method to Identify Other Residents At Risk for Deficient Practice: All smoke detectors in the kitchen area and dish machine room were checked an no others were found to be covered Other fans in kitchen area were checked and cleaned if needed. 3. Measures or Systemic Changes to Ensure Deficient Practic Does Not Recur: Re-educate staff on observation/cleaning of fan and fan coi surfaces, and appropriate notification to supervisor if damage or soiled surfaces are observed. Maintenance to clean/repair. Bay City Pest control contractor notified to increase checks in dish machine room. Roof mounted exhaust fan scheduled for install in dish machine room to draw excess steam and moisture from room. On a monthly basis, kitchen areas will be randomly checke by Director of Dining Services to ensure deficient practice does not recur. Performance Monitoring to Ensure Solutions Are Sustainer Report findings in Quarterfy QA meeting. Implementation date: July 24, 2008 and quarterfy thereafter x 4 quarters.		6/30/08			
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